EXHIBIT 5

NOTICE OF CLAIM **SUMMONS** 7901053

STATE OF INDIANA
COUNTY OF MARION, ss:

In the MARION COUNTY
SMALL CLAIMS COURT
LAWRENCE TOWNSHIP DIVISION
4455 McCOY STREET
LAWRENCE, INDIANA 46226
(317) 545-2369

MED-1 SOLUTIONS, LLC
As agent for Collection for COMMUNITY HEALTH NETWORK
517 US Highway 31 N
Greenwood, IN 46142
Plaintiff,

vs.

ANN MARIE ROBBINS
8118 BROOKMONT CT Unit 101 INDIANAPOLIS IN 46278
Defendant.

CAUSE NO: 49K03- 1407 -SC 003946

The said Plaintiff complains of the Defendant and says: That the Defendant is indebted to the Plaintiff in the sum of $ 1804.00 for the reason stated herein: Unpaid balance for medical services:$1499.00, a copy of which billing statement is attached, reasonable attorney fees if awarded by court ($375.00), of which consent form is attached hereto as Exhibits "A" and "B".
And hereby demands judgment, court costs, and all other proper relief.

Dated: 6/26/14 FILED

JUL 01 2014

SMALL CLAIMS COURT
LAWRENCE TOWNSHIP DIV.

Plaintiff's Attorney
517 US Highway 31 N
Greenwood, IN 46142
(317) 883-5600

TO ANY CONSTABLE OF THIS TOWNSHIP: You are hereby commanded to summon ANN MARIE ROBBINSto appear before me in court on 8-6-14 at _____ o'clock M. to answer the Plaintiff in a trial hearing on the above claim and to make due return of this Notice of Claim.

Dated: JUL 01 2014

Judge

CONSTABLES RETURN OF SERVICE OF NOTICE OF CLAIM:
I certify that I have served this Notice of Claim on ANN MARIE ROBBINS
1) By reading a copy of the Notice of Claim to the Defendant,_____.
2) By leaving a copy of the Notice of Claim at _____, which is the dwelling place or usual place of abode of Defendant and by mailing a copy of the Notice of Claim to said Defendant at such address.
3) Other service or remarks: _____

Constable

NOTICE TO ALL PARTIES:

- You are notified that you have been sued by the person(s) named Plaintiff in the court indicated
- The nature of the claim against you and the demand made against you by the Plaintiff is stated in the claim.
- You may appear either in person or by attorney on the date set for trail and hearing of Plaintiff's claim.
- Both the Plaintiff and the Defendant should bring to the hearing all witnesses and all documents in their possession concerning this claim.
- If the Defendant does not wish to dispute the claim of the Plaintiff he may appear to consent to a judgment and for the purpose of allowing the court to establish the method by which the judgment shall be paid
- If the Defendant cannot appear at the time and place set in the notice he should contact the court to request that the hearing be continued to another date
- If the Defendant fails to appear in Court at the time set for the hearing a default judgment may be entered against the Defendant.
- The filing of a civil claim in the Small Claims Court constitutes a waiver of trial by jury by the Plaintiff.
- Defendant has a right to a Jury Trial, but such right is waived unless a Jury Trial is requested within ten (10) days after receipt of this Notice of Claim.

ACCOUNT BALANCE FOR COMMUNITY HEALTH NETWORK

ACCOUNT #:90100203986
PATIENT NAME: Aiden Russell Robbins
DATE OF SERVICE: 09/05/13
BALANCE: 582.19
RESPONSIBLE PARTY: ANN MARIE ROBBINS
8118 BROOKMONT CT Unit 101
INDIANAPOLIS IN 46278

DATE LISTED WITH MED-1: 02/19/14

THIS COMMUNICATION IS FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT, AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

ACCOUNT BALANCE FOR COMMUNITY HEALTH NETWORK

ACCOUNT #:90100203989
PATIENT NAME: Ronan Michael Robbins
DATE OF SERVICE: 09/05/13
BALANCE: 916.81
RESPONSIBLE PARTY: ANN MARIE ROBBINS
8118 BROOKMONT CT Unit 101
INDIANAPOLIS IN 46278

DATE LISTED WITH MED-1: 02/19/14

THIS COMMUNICATION IS FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT, AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

A

Community Health Network

MR# 005512873 CSN# 10012815966
[redacted] BABY BOY A 9/5/2013 1439
[redacted] PC: Newborn
[redacted] MD North

PATIENT CONSENT AGREEMENT
(PAGE 1 OF 2)

THIS PATIENT CONSENT AGREEMENT applies to services provided by Community Health Network, Inc., Community Hospital North, Community Hospital East, Community Hospital South, Community Heart and Vascular Hospital, Community Physician Network, Community Home Health, Community Surgery Center North, Community Surgery Center East, Community Surgery Center South, Community Surgery Center Hamilton, Community Surgery Center Northwest, Community Endoscopy Center Indianapolis and Community Digestive Center Anderson (each of these health care providers whether individually licensed or operating under the license of another hereinafter referred to collectively as "Community"). ***This Patient Consent Agreement is valid for up to one year for all physician practice and outpatient services provided by Community.***

Medical Treatment
I request or authorize Community to provide and perform under the direction of my physician(s) and/or his/her designee such care, procedures, services and supplies as are considered advisable for my health and wellbeing. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me by my physician(s) or Community as to the result of any treatments, examinations, procedures or other services provided by Community. I authorize Community to dispose of any tissue, severed or amputated member, body part, or medical device removed in connection with services provided by Community. I understand that it is the responsibility of the physician to explain to me the nature of any diagnostic, therapeutic, medical and/or surgical procedures necessary to treat me and to explain risks and consequences associated with the services.

Patient Rights and Advance Directives
If I am receiving hospital inpatient services, ambulatory surgical center services or home health services, I acknowledge I have been given written materials on my patient rights and responsibilities, which include my right to an advance directive. For all other Community services, I understand that information about advance directives is available upon request.

Consent to Release Medical Records
I understand Community will make every effort to treat my medical record information as confidential; however, I realize information must be shared with other providers involved in my care or in the payment of my care. Further, I understand other healthcare providers involved in my care will have access to my medical information. I consent to the release of my medical information for treatment, payment and health care operational purposes as allowed by state and federal law, including the release of communicable disease information.

Legal Relationships
I understand my services may be provided by: (1) health care providers who are not employees of Community but who have a contract with Community to provide services, such as emergency physicians, anesthesiologists, radiologists, pathologists and other independent physicians; and (2) health care providers who have no employment or other contractual relationship with Community; and these providers may or may not participate in my insurance plan. I understand Community is responsible for carrying out the instructions of such providers, but I acknowledge (a) such providers are not employees or agents of Community; and (b) **Community is <u>not</u> responsible for the medical decisions, acts or omissions of such providers.**

Assignment of Insurance Benefits
I assign payment to: (1) Community; (2) health care providers who are not employees of Community, but who have a contract with Community to provide services, such as emergency physicians, anesthesiologists, radiologists, and pathologists; and (3) health care providers who have no employment or other contractual relationship with Community. I understand I will receive separate bills for services ordered or rendered by providers who are not employees of Community and who may or may not participate in my insurance plan.

I understand Community verifies my benefits and/or bills my insurance company as a courtesy to me. I authorize Community to release to Medicare and its agents any information needed to determine my benefits for services received. I authorize the release of my medical records and any other information necessary to obtain payment from Medicare, Medicaid and other payers.
Continued...

Community Health Network

MR# 005512873 CSN# 10012815966
ROBBINS,BABY BOY A 9/5/2013 1439
[redacted] PC: Newborn
Jennifer S. Hill-Birk MD North

PATIENT CONSENT AGREEMENT (PAGE 2 OF 2)

Assignment of Insurance Benefits *(Continued)*
I request that payment of authorized benefits from Medicare, Medicaid and other payers be made on my behalf to Community for services provided by Community. This assignment does not apply to patients with insurance that is not accepted by Community.

Further, I understand that verification of my benefits is not a guarantee the insurance company will pay those benefits and I am responsible for ensuring that any prior authorization required for my services is obtained in advance of treatment. In addition, I hereby appoint Community and its employees and agents as my representative to file grievances and appeals for me with my insurance plan/HMO as allowed by Indiana State law.

Responsibility for Payment
I understand that I may request and receive an estimate of anticipated charges. I understand and acknowledge that an estimate is not a guarantee; that the estimate is not binding upon Community; and that actual charges will be determined based on the services I receive and may be more or less than the estimate. I understand that I am financially responsible for all amounts not paid by insurance or other payers for services provided to me by Community and I agree to pay all charges when due or in accordance with any financial arrangement made at the time of discharge.

I understand Community provides financial assistance in the form of reduced charges, payment options, and payment plans to those who qualify. I understand I can request additional information on payment options or financial assistance if I believe I may not be able to pay or may not be able to pay timely.

In the event I do not pay such charges when due, I agree to pay costs of collection, including attorney fees and interest. I authorize Community or its agent to access my credit report in order to collect any charges due. If I provide Community with my cell phone number, I authorize Community or its agent to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe.

Release of Responsibility for Valuables
I understand that Community is not liable for personal possessions including, but not limited to, money, valuables, dentures, eyeglasses, hearing aids or other property, that are lost or damaged. I know Community has the right to search anything on its premises, including wallets and purses, for the safety and welfare of its patients and visitors. I know I can avoid having my possessions searched by sending them home.

Receipt of Notice of Privacy Practices
I acknowledge that I have received the Community Health Network Notice of Privacy Practices and understand that I can also access a copy at www.eCommunity.com.

I acknowledge that I have read and agree to pages 1 and 2 of this Patient Consent Agreement and my questions have been answered. I understand that I can request a copy of this document.

[redacted]	9/5/13	
Patient/Legal Representative Signature	Date	Relationship (if not patient)
Guarantor Signature (if other than patient/legal representative)	Date	Relationship
[redacted]	9/5/13	
Witness Signature	Date	Time

B

Community Health Network

MR# 005512875 CSN# 10012816065
ROBBINS,BABY BOY B 9/5/2013 1440
[redacted] PC: Newborn
Jennifer S. Hill-Birk MD North

PATIENT CONSENT AGREEMENT
(PAGE 1 OF 2)

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Continued...

Community Health Network

MR# 005512875 CSN# 10012816065
ROBBINS,BABY BOY B 9/5/2013 1440
[redacted] PC: Newborn
Jennifer S. Hill-Birk MD North

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*Patient/Legal Representative Signature	Date	Relationship (if not patient)
Guarantor Signature (if other than patient/legal representative)	Date	Relationship
[signature]	9/5/13	
Witness Signature	Date	Time